

Birth & Death

1600

55

10458

MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Hyattstown
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution: Washington County Hospital
Length of mother's stay in County _____
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Hyattstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 428 N. Mulberry
(If RURAL give LOCATION)

3. Name of child Baby Bill Alexander
5. Sex Female 6. Twin or triplet _____

4. Date of birth 10 - 1 1946 Hour 10:35 AM
7. No. of weeks pregnancy _____

FATHER OF CHILD

8. Full name Harold A. Alexander
9. Color W 10. Age at time of this birth 30 yrs.
11. Usual occupation Aircraft

MOTHER OF CHILD

12. Full maiden name Lee Ruth Boward
13. Color W 14. Age at time of this birth 28 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
(b) How many other children were born alive but are now dead? 6 (c) How many other children were born dead? 0

17. Did child die before labor? no During labor? no
18. Pregnancy, complications of Breech presentation
maternal negative; fetal positive
19. Labor: (a) Complications of Breech presentation (b) Induced? no
20. (a) Was there an operation for delivery? yes (Yes or No)
(b) State all operations, if any Breech extraction
(c) Did child die before operation? no
During operation? _____

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Placental hemorrhage
(b) Maternal causes _____
22. I certify to the birth of this child who was born dead* on the date and hour above stated.
Signature Electa Baptista
(Specify if M.D., midwife, or other)
Address 214 N. Patuxent Paceside

23. (a) Burial (b) Date thereof 10/2/46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
24. (a) Funeral director Woodford Mortuary
(b) Address 308 S. Potomac St.

25. (a) _____ (b) _____
(Date rec'd by registrar) (Registrar)
26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.
Health Officer, per _____

* See Instruction C on stub.

Lived 2 hours - 55 min.

V. S. A10

T

RECEIVED
OCT 4 1946
BUREAU OF V E

Evidence for the age is

Dr. Prather

38

shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a



10341

FILM No. I O 8 NOV - 4 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

112 S. Prospect St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 112 North Prospect St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

MISS LULU STAKE ANKENY

3. (b) Social Security Number

213-01-8009A4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife -----6.(c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) August 21, 18778. AGE: Years 69 Months 06 Days 2 It less than one day 0 hrs. --- min.9. Birthplace Clear Spring Washington Co., Md.
(Town, county, and state)10. Usual occupation Telephone Operator11. Industry or business Retired12. Name David Newcomer Ankeney13. Birthplace Hagerstown Md.14. Maiden name Sallie E. Seible15. Birthplace Clears Spring Md.16. Informant Miss Blanche AnkeneyAddress Hagerstown Md.17. Burial ✓ Date thereof 10/24/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Pauls CemeteryLocation Near Clear Spring Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 24. 46 Charles Bower
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 21 19 46 at 10:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 21 19 46 to Oct 21 19 46
and that I last saw her alive on Oct. 21 19 46

Immediate cause of death

Cerebral hemorrhage DURATION 1/2 hourDue to Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. otherAddress Hagerstown, Md. Date signed Oct. 22. 46

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 26 1946
BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10342

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Chewsville
(If outside city or town limits, write RURAL and give nearest town)Street No. ---
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

CALVIN TRACEY BACHTELL

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife Lutia6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) November 6 18648. AGE: Years Months Days If less than one day
81 11 0 hrs. min.9. Birthplace Chewsville Wash. Co. Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Daniel Bachtell13. Birthplace Chewsville Md.14. Maiden name Barbara Coss15. Birthplace Chewsville Md16. Informant Merle L. BachtellAddress Hagerstown Md.17. Burial Date thereof 10/8/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg CemeteryLocation Smithsburg Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 8, '46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1946 at 4:45 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/26/46 to 10/6/46and that I last saw him alive on 10/5/46Immediate cause of death Hypertrophy ofProstate DURATION several
Years

Due to

Due to

Other conditions Senility, general debilityarteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations Prostatic Hypertrophywith cystitis Date of op. 9/19/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. Brumbach M. D. or otherAddress Hagerstown Md. Date signed 10/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 10 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred:
119 North Foundry St.

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 North Foundry St.
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

CHARLES EDWIN BLOCKER

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife. ---

7. Birth date of deceased (mo., day, yr.) December 2, 1885
 8. AGE: Years 60 Months 10 Days 7 If less than one day --- hrs. --- min.

9. Birthplace Chambersburg Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation Taxi Driver11. Industry or business Own Cab12. Name Jacob Blocker13. Birthplace Lancaster Penna.14. Maiden name Margret Carnes15. Birthplace Pleasant Hill Penna.16. Informant Mrs. Walters WilesAddress Route #3 Chambersburg Penna.17. Burial Rose Hill Cemetery Date thereof 10/12/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hagerstown Md.Location Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 12, 1946 Registrar Charles H. Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct. 9 19 46 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE S. Richard Wells DEPUTY MEDICAL EXAM.Address Hagerstown Md. Date signed Oct. 9-46

RECEIVED

OCT 15 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Dr. Prather

10344

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Years
 Hospital, institution, or street address where death occurred:
19 E. Franklin St.
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 19 E. Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS RUTH CATHERINE BOYER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Grover O. Boyer
 6.(c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) February 24, 1888
 8. AGE: Years 56 Months 7 Days 24 If less than one day --- hrs. --- min.

9. Birthplace Waynesboro Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home Melrose Melrose

12. Name John D. Stoler

13. Birthplace Waynesboro Pa.

14. Maiden name Angelina Reese

15. Birthplace Fairfield Pa.

16. Informant John Melvin Miller

Address Hagerstown Md.

17. Burial 10/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 19, 46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 46 at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944 19 --- to Oct. 18 19 46
 and that I last saw her alive on Oct. 17 19 46

Immediate cause of death Vaginal hemorrhage

Acute myeloid leukemia

Due to Carcinoma of uterus

Other conditions 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury --- Injured at work? ---

23. SIGNATURE Dr. Prather

M. D. of ---

Address Hagerstown Date signed 10/18/46

RECEIVED

OCT 22 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. wells

2411 N. Charles St., Baltimore

(940)

10345

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:

Western PikeHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Western Pike
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

JOHN EDWARD BURTMAN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white single6. (b) Name of husband or wife --7. Birth date of deceased (mo., day, yr.) March 4 1884

8. AGE: Years Months Days If less than one day

62 7 6 hrs. min.9. Birthplace Waynesboro Franklin Co. Pa.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Farm12. Name No Record13. Birthplace No Record14. Maiden name Lydia Burtman15. Birthplace Five Forks Pa.16. Informant Mrs. Emerson DonatAddress Hagerstown Md.17. Burial Date thereof 10/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill cemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 17, 46 Chas H Bowser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 14 1946 at 1.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19Immediate cause of death Acute coronary occlusionDue to Acute coronary occlusionDue to Acute coronary occlusionOther conditions Acute coronary occlusion

(Include pregnancy within 3 months of death)

Major findings of operations Acute coronary occlusionDate of op. Acute coronary occlusionAutopsy results Acute coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of Acute coronary occlusionWhere did injury occur? Acute coronary occlusion (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Acute coronary occlusionMeans of injury Acute coronary occlusion Injured at work?23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.Address Hagerstown, Md. Date signed Oct. 16, 46

RECEIVED

OCT 19 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

Dr. Norment

10346

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Dual Highway
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

ALFRED GILMER CAMPBELL

3. (b) Social Security Number

170-01-4812

4. Sex Male 5. Color or race White 8. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary 8. (c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) May 4 1893
 8. AGE: Years 53 Months 5 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Fincastle Botetourt Co. Va.
 (Town, county, and state)
N. & W. R. R?
 10. Usual occupation Engineer
 11. Industry or business Engineer

FATHER 12. Name Alfred L. Campbell
 13. Birthplace Fincastle Va.
 MOTHER 14. Maiden name No Record
 15. Birthplace No Record
 18. Informant Mrs. Mary Campbell
 Address Hagerstown Md. R#1

17. Burial 10/16/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct. 16. 46 Shirley Rowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946 19 46 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1946 to October 14 1946
 and that I last saw him alive on October 14 1946

Immediate cause of death Brain Tumor; DURATION 3 mos
 Due to Malignant Glioma; Cerebral
Left parietal lobe. Duration 6 months.
 Due to Cerebral spinal pyphosis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations Brain tumor Date of op. _____
 Autopsy results Brain tumor
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Dr. Norment M. D. or other _____
 Address Hagerstown Md Date signed 10/16/46

RECEIVED
OCT 18 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9820

CERTIFICATE OF DEATH

10347
Reg. Dist. No. 302

1. PLACE OF DEATH: *Washington*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *35 years*
Hospital, institution, or street address where death occurred:
332 Blooms Court
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Maryland* County.....*Washington*
City or town.....*Hagerstown*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *332 Blooms Court*
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *Leargie Anna Cotton* 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *Negro* 6. (a) Single, married, widowed, or divorced *Widow*
6. (b) Name of husband or wife *Charles Cotton*

7. Birth date of deceased (mo., day, yr.) *5/12/1891* 6. (c) If alive, give age..... years

8. AGE: Years *55* Months *5* Days *4* If less than one day..... hrs. min.

9. Birthplace *Front Royal, Va.*
(Town, county, and state)

10. Usual occupation *Domestic*

11. Industry or business

12. Name *Jack French*

13. Birthplace *Richmond, Va*

14. Maiden name *Sarah Franklin*

15. Birthplace *Little Washington, Va*

16. Informant *Mrs. Christine Styles*

Address *130 W. North Street*

17. *Burial* Date thereof *10/19/46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Rose Hill Cemetery*

Location *Hagerstown, Md.*

18. Funeral director *William H. Wray*

Address *2801 Oak & Hagerstown*

19. *Oct 19 46* Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 16 46* at *10:4* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

acute cerebral hemorrhage

Due to.....

Vascular hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... *no*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.

23. SIGNATURE *Robert Wells* WASH. CO., MD.

Address *Hagerstown, Md.* Date signed *Oct 18/46*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 22 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10348

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 302 S. Mulberry Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Rebecca J. Crosswhite

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife John M. Crosswhite

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1859

8. AGE: Years 86 Months 10 Days 22 If less than one day
 hrs. min.

9. Birthplace Carter County, Tennessee
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name Roberts13. Birthplace Tennessee14. Maiden name Mahale15. Birthplace Tennessee16. Informant Jesse H. CrosswhiteAddress 16 Beckley Avenue- Hagerstown,17. Removal Oct. 11-46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Union CemeteryLocation Johnson City, Tennessee (Rural18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Oct. 9, 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1946 11 39 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 16 1946, to Oct 8 1946
 and that I last saw him alive on Oct 8 1946

Immediate cause of death Pneumonia, bacterial, left base
 DURATION 18 hours

Due to.....

Due to.....

Other conditions Hypertension, cardiac, vascular, renal disease 2 years.
 (Include pregnancy within 8 months of death)
 Major findings of operations.....
 Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.
Md.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. Layman, M.D.Address 100 Professional Arts Bldg, Hagerstown, Md.
Date signed 9 Oct 46

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OCT 11 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B3a

CERTIFICATE OF DEATH

10349
Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Haystack
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 year
 Hospital, institution, or street address where death occurred:
Washington County Hosp.
 How long in hospital or institution?..... 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Haystack
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 329 1/2 N. Jonathan Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Hannah Jane Davis

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... negro 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Levis B. Davis
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... May 6, 1882
 8. AGE: Years..... 64 Months..... 5 Days..... 20 If less than one day..... hrs. min.

9. Birthplace..... Waverly Md.
 (Town, county, and state)
 10. Usual occupation..... Domestic
 11. Industry or business.....

FATHER 12. Name..... Buy Fisher
 13. Birthplace..... Wenertown, Md.
 MOTHER 14. Maiden name..... Mary Pollard
 15. Birthplace..... Wenertown, Md.

16. Informant..... Mrs. Bessie King
 Address..... 335 N. Jonathan St.
 17. Burial Date thereof..... 10/30/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Mount Mariah
 Location..... Wenertown, Md.

18. Funeral director..... William H. Brown
 Address..... 291 Fredrick St. Haystack

19. Oct. 30 19 46 Blair Boward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 26 19 46 at 9:15 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 25 19 46 to Oct 26 19 46
 and that I last saw him alive on Oct 26 19 46

Immediate cause of death.....
Cerebral Hemorrhage
Arteriosclerosis
Hypertension
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

DURATION
1 day
 ?
 ?

Major findings of operations.....
 Date of op.....
 Autopsy results..... Cerebral Hemorrhage, Arteriosclerosis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Blair Boward M. D. or other
 Address..... 159 W. Washington St. Date signed..... 10/29/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 1 1945
MORI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

10350

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Clarendon Ave.
 (If rural, give LOCATION)
none

2.(a) If veteran, name war

3.(a) FULL NAME

Woodrow Miller Dennis

3.(b) Social Security Number

477-16-6384

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Orpha Blair Dennis6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 19, 1916

8. AGE: Years 30 Months 6 Days 14 It less than one day -- hrs. -- min.

9. Birthplace Charlestown, Jefferson Co., W. Va.
 (Town, county, and state)

10. Usual occupation Houseman11. Industry or business Hotel Alexander12. Name Oscar Dennis13. Birthplace Luray Va.14. Maiden name Essie Sowers15. Birthplace Luray Va.16. Informant Mrs. Orpha DennisAddress Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 6, 1946
 (month) (day) (year)

Cemetery or crematory Little Rose Hill CemeteryLocation Clearspring Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 5, 46 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 19 46 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 30 - 46 to Sept 30 - 46
 and that I last saw him alive on Oct 3 - 46 19 46

Immediate cause of death

DURATION

Respiratory Endocarditis 3 Wks
 Due to Septic int. pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or other

Address Hagerstown Md. Date signed 10/5/46

RECEIVED
OCT 8 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10351

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Chewsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
Hagerstown
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Chewsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ---
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

ABNER FUNK DOUB

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Susannah

7. Birth date of deceased (mo., day, yr.) February 1 1865
 6. (c) If alive, give age - years

8. AGE: Years 81 Months 8 Days 5 If less than one day --- hrs. --- min.

9. Birthplace Beaver Creek Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name David R. Doub

13. Birthplace Beaver creek Md.

14. Maiden name Catherine Funk

15. Birthplace Beaver Creek Md.

16. Informant Mr A. LeRoy Doub

Address Smithsburg Md R # 2

17. Burial Date thereof 10/8/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md

19. Oct. 8. 46 Registrar Bluff Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1946 at 10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1940 to Oct 6 1946, and that I last saw him alive on June 2 1946.

Immediate cause of death Hypertensive Cardiovascular Disease DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lidney Koversten M.D.

Address Chewsville Md Date signed 10/7/46

RECEIVED

OCT 10 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

10352

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 41 years
 Hospital, institution, or street address where death occurred:
Heisterboro Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Heisterboro Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bertha Elizabeth Drury

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife..... <u>Ernest M. Drury</u>			
7. Birth date of deceased (mo., day, yr.) <u>February 28, 1879</u>			
8. AGE: Years <u>67</u>	Months <u>7</u>	Days <u>21</u>	If less than one day hrs. min.

9. Birthplace..... Locust Grove, Maryland
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....

FATHER	12. Name..... <u>Samuel Smith</u>
	13. Birthplace..... <u>Washington County, Md.</u>
MOTHER	14. Maiden name..... <u>Anna M. Gross</u>
	15. Birthplace..... <u>Washington County, Md.</u>

16. Informant..... Alvin E. Drury
 Address..... Hagerstown, Maryland

17. Burial..... Burial Date thereof..... 10-21-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Oct. 19, 46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19 Oct 19. 46 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
16 Oct 19. 46 to 19 Oct 19. 46
 and that I last saw him alive on 18 Oct 19. 46

Immediate cause of death..... Arterio sclerotic Heart Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Inf

..... Date of op.

Autopsy results..... mt

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. J. Lusby M. D. or other

Address..... 2301 Potomac Date signed..... 10/19/46

RECEIVED
OCT 22 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County: Hagerstown
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
 43 E. Washington St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Washington
 State: Hagerstown
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 Street No. 43 E. Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Minnie C. Funk

3. (b) Social Security Number

4. Sex Female
 5. Color or race White
 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife S.M. Funk
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) August 19 1877
 8. AGE: Years 69 Months 1 Days 15
 If less than one day

9. Birthplace Near Hagerstown Wash. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name David C. Hoover
 13. Birthplace Near Leitersburg Md.
 14. Maiden name Anna Mary Wishard
 15. Birthplace Near Leitersburg Md.

16. Informant Mr. S.M. Funk
 Address Hagerstown Md.
 Burial 10-17-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. Oct. 17. 46 Black/Browne
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 46 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 19.46, to Oct. 14 19.46
 and that I last saw her alive on Oct. 12 19.46

Immediate cause of death Cerebral Stroke
 Duration

Due to Impenitent
 Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Stauffer

M. D. or other

Address Hagerstown Md. Date signed Oct. 15 46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 19 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 301

10354

1. PLACE OF DEATH:

County... Washington CountyCity or town... Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

14 East Potomac St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town... Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 E. Potomac St.
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

Mrs. Annie Gaylor

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Clarence Gaylor
deceased

7. Birth date of

deceased (mo., day, yr.) Oct. 14 1874

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

725

...hrs. ...min.

9. Birthplace... Sharpsburg Maryland
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business Home12. Name Unknown

13. Birthplace

14. Maiden name... Mrs. Cunningham (adoptedMother) Sharpsburg Md.18. Informant Mr. Lewis GaylorAddress 14 East Potomac St. Williamsport Md17. Burial Date thereof Oct. 23 1946
(Burial, cremation, or removal. Which? (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Maryland18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. Oct. 23 19 46 Mrs. E. Lee McChoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/46 19 46 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/19/46 19 46 to 10/19/46 19 46and that I last saw him alive on 10/19/46 19 46Immediate cause of death Cerebral

DURATION

4 mo.

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. Young M. D. or otherAddress Williamsport Md Date signed 10/22/46

RECEIVED
OCT 24 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

-Dr. Campbell

10355
Reg. Dist. No. 3031

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Months
 Hospital, institution, or street address where death occurred:
Layman Nursing Home
 How long in hospital or institution? 7 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1019 Virginia Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

WILLIAM JAMES GRAHAM

3. (b) Social Security Number

4. Sex Male 5. Color, or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Cora
 6. (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) February 14, 1876

8. AGE: Years 76 Months 8 Days 6 If less than one day -- hrs. -- min.

9. Birthplace Union Bridge Carrol Co. Md.
 (Town, county, and state)

10. Usual occupation Driver, Railway Express

11. Industry or business Retired

12. Name Peter Graham

13. Birthplace Union Bridge Md.

14. Maiden name Catherine Hess

15. Birthplace Union Bridge Md.

16. Informant Mrs. Charles Backley

Address Hagerstown

17. Burial Date thereof 10/23/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Union Bridge Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 22 1946 Ray M. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1946, at 12:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1945, to Oct 20 1946, and that I last saw him alive on Oct 20 1946.

Immediate cause of death Congestion of Heart Failure DURATION 2 M.
 Due to Cardio-Vascular Disease 2 years.
 Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? None (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) None
 Means of Injury None Injured at work? None

23. SIGNATURE Dr. Campbell M. D. or other None
 Address Hagerstown Md. Date signed 10/21/46

RECEIVED

DEC 6 1946

RECEIVED

2-40

2-3030 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490 X

CERTIFICATE OF DEATH

Dr. Porterfield



Reg. Dist. No. 103501

1. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
23 Frederick St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 23 Frederick St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS MARY JANE HAMMOND

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Christian
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) January 20 1878
 8. AGE: Years 68 Months 9 Days 4 If less than one day - hrs. - min.

9. Birthplace Bakersville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Daniel Warraduke
 13. Birthplace Bakersville Md.
 14. Maiden name Alice Cook
 15. Birthplace Bakersville Md.

16. Informant Carl E. Hammond
 Address Hagerstown Md.

17. Burial Bakersville Cemetery Date thereof 10/27/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bakersville Md.
 Location Bakersville Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct 27 1946 Registrar Mrs C L McElroy
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946 19 46 at 5.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1946 to Oct 24 1946
 and that I last saw him alive on Oct 24 1946

Immediate cause of death

Carcinoma left ovary

DURATION

3

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

H Porterfield M.D.

M. D. or other

Address 136 W Washington Date signed 6/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

DeENERLEY 26

10357

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 22 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 5
 (If outside city or town limits, write RURAL and give nearest town)
Security
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

William Elsworth Hays
~~UNNAMED CHILD OF THOMAS W. HAYS~~

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife -----
 6. (c) If alive, give age ----- years
 7. Birth date of deceased (mo., day, yr.) October 14 1946
 8. AGE: Years ----- Months ----- Days ----- if less than one day
22 hrs. ----- min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business -----

FATHER
 12. Name Thomas W. Hays
 13. Birthplace Myersville Md.
 MOTHER
 14. Maiden name Madaline Hatfield
 15. Birthplace Hagerstown Md.

16. Informant Thomas W. Hays
 Address Hagerstown Md. R # 5

17. Burial Date thereof 10/16/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
 Location Andrew K. Coffman

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct. 16, 46 Blanch Rowser
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1946 19 ----- at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 14, 1946 19 ----- to Oct. 15, 1946
 and that I last saw him alive on Oct. 13, 1946 19 -----

Immediate cause of death Prematurity (22 weeks)
 DURATION 26 hrs

Due to -----
 Due to -----
 Other conditions -----
 (Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ----- Date of -----
 Where did injury occur? ----- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -----
 Means of injury ----- Injured at work? -----

23. SIGNATURE B. B. Schneider, M.D.
 Address 148 W. Washington St. Date signed 10/16/46

RECEIVED
OCT 18 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

10358

Reg. Diat. No. 881

1. PLACE OF DEATH:

County Washington
 City or town Williamsport Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Blessing C.B.N. Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pg County Fulton Pa.
 City or town Shippensburg P.D. 3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.D. 3.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Raymond Eugene Hock

3. (b) Social Security Number

none

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 13, 1944

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

2

3

8

hrs.

min.

9. Birthplace

Chambersburg Pa
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1946 to Oct 22 1946 and that I last saw him alive on Oct 22 1946

Immediate cause of death

Status hyperaemic

DURATION

30 MIN.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Williamsport Pa Date signed 10/22/46

RECEIVED
OCT 24 1948
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. B.B. Kniesly¹⁸

10359

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 243 Mealey Place
(If rural, give LOCATION)2.(a) If veteran, name war None

3.(a) FULL NAME

ROBERT PERRIN HUSSEY

3.(b) Social Security Number

314-09-8110

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Helen Jones Hussey6.(c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) July 21, 18908. AGE: Years Months Days If less than one day
56 2 21 -- hrs. -- min.9. Birthplace Falconer, Chautauqua Co., New York
(Town, county, and state)10. Usual occupation Manager11. Industry or business Service DepartmentFATHER 12. Name George Hussey13. Birthplace EnglandMOTHER 14. Maiden name Susie Perrin15. Birthplace Falconer16. Informant Mrs. Helen J. HusseyAddress Hagerstown Md.17. Burial Date thereof 10/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Levant CemeteryLocation Falconer, New York18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 12, 1946 Charles H. Boward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1946 at 1946 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8, 1946 to October 12, 1946 and that I last saw him alive on October 11, 1946Immediate cause of death Cerebral Hemorrhage DURATION 3 days

Due to

Other conditions Coronary sclerosis 5 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B.B. Kniesly M.D. or otherAddress 148 W. Washington St. Date signed 10/12/46

RECEIVED

OCT 15 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1960

CERTIFICATE OF DEATH

10360
Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Williamsport R#2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 Years
 Hospital, institution, or street address where death occurred:
Williamsport R#2
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport R#2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wilsons
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. CORA ELIZABETH JOHNSON

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife B. F. Johnson
 6. (c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) Sept. 1, 1870

8. AGE: Years 76 Months 1 Days 11 It less than one day
 — hrs. — min.

9. Birthplace Huyette, Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Saunuel Needy
 13. Birthplace Huyette Md.

MOTHER 14. Maiden name Louise Hauer
 15. Birthplace Huyette Md.

16. Informant B.F. Johnson
 Address Williamsport

17. Burial Burial Date thereof 10/14/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Near Clearspring Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct 13 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 19 46 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 1938 Oct. 12 46
 and that I last saw him alive on October 11 19 46

Immediate cause of death Hypertension Cerebral Hemorrhage
 DURATION 1 week

Due to Hypertension Cardio Vascular
Renal disease 10 years

Due to Alcohol's Chronic 13 years

Other conditions Alcohol's Chronic

(Include pregnancy within 3 months of death)
 Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE Paul Robert Cole
 M. D. None

Address Clear Spring Md. Date signed 10-12-46

OCT 17 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

10361

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred

Washington County Hospital

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 W. North Street.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Elizabeth Jones

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William Jones

7. Birth date of

deceased (mo., day, yr.)

April 15, 1875

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71

6

12

hrs.

min.

9. Birthplace

Winchester, Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Wattie Smith

13. Birthplace

Winchester Va

14. Maiden name

Milly Mosley

15. Birthplace

Winchester, Va.

16. Informant

Mrs Samuel Johns

Address

54 W. North Street.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

William H. Downey

Address

291 Frederick St. Hagerstown

Oct. 29. 46

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct 46 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 46 27 Oct 46

and that I last saw him alive on 27 Oct 46

Immediate cause of death

Pneumonia, bacterial

DURATION

20 yrs

Due to

Due to

Other conditions

Cancer, breast, left

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kneisley

27

10362

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Days
 Hospital, institution, or street address where death occurred:
Hill Crest Nursing Home
 How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown Ave
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 116 Wayside Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

MRS ANNA CHRISTINA KEIRN

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Abraham
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) November 8 1869
 8. AGE: Years 76 Months 11 Days 7 If less than one day - hrs. - min.

9. Birthplace Baltimore Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Andrew J. Sinners
 13. Birthplace Baltimore Md.
 14. Maiden name Rosina Morlock
 15. Birthplace Baltimore Md.

16. Informant Miss Mildred Keirn
 Address Hagerstown Md.
 17. Burial Date thereof 10/18/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory First Evan Church Cemetery
 Location Baltimore Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. Oct. 16. 46 Chas H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1946 19 46 at 7 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 11, 1946 19 46 to October 15, 1946
 and that I last saw her alive on October 7, 1946 19 46

Immediate cause of death Chronic myocarditis with congestive failure
 DURATION 5 yrs
 Due to -
 Due to -
 Other conditions multiple hypertrophic arthritis 15 yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -
 Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? - (City or town) - (County) - (State)
 Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -
 23. SIGNATURE B. B. Kneisley M.D.
 Address 148 W. Washington St. Date signed 10/16/46

RECEIVED
OCT 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

10363

Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington
 City or town Hagerstown and
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, institution, or street address where death occurred:

Washington County Hospital
5 mos.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Leanstown and
 (If outside city or town limits, write RURAL and give nearest town)

Street No. none
 (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Henry, Jacob. Keller

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

none

7. Birth date of
 deceased (mo., day, yr.)

12-26-18896. (c) If alive, give age. — years

8. AGE:

Years	Months	Days	If less than one day
<u>91-</u>	<u>9-</u>	<u>12</u>	<u>—</u> hrs. <u>—</u> min.

9. Birthplace

Lebanonville, York Co. Pa
 (Town, county, and state)

10. Usual occupation

Country Egg Business

11. Industry or business

"S. Keller"

FATHER

12. Name

Henry S. Keller

13. Birthplace

Lebanonville, York Co. Pa

MOTHER

14. Maiden name

Hennetta Newley

15. Birthplace

Lebanonville, York Co. Pa

16. Informant

Co. Lester, Burgess

Address

Leanstown and

17.

Burial

Date thereof

10-10-1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Leanstown

Location

Leanstown and

18. Funeral director

Geo. B. Hoover

Address

Smithsburg and

19.

Oct 9, 46

(Date rec'd by registrar)

Dr. East/Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1946 at 5:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6 1946 to Oct 8 1946and that I last saw him alive on Oct 8 1946

Immediate cause of death

Hypertatic Pneumonia, 2 days

DURATION

Due to

Fracture of neck of femur 4 mks

Due to

Left half of steps on

Other conditions

Concrete walk

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. B. Hoover

M. D. or other

Address Smithsburg Date signed 10/8/46

RECEIVED

OCT 11 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

10364

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 12 days
Hospital, institution, or street address where death occurred:
Claire Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Claire Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Dianne Marie King

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1946

8. AGE: Years 0 Months 1 Days 12 If less than one day
.....hrs.min.

9. Birthplace Hagerstown, Washington, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Donald King
13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Magdeline Hensley
15. Birthplace Shawsville, Pa.

16. Informant Donald King
Address Claire St- Hagerstown, Md.

17. Burial Date thereof Oct. 15-46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Oct. 15, 46 Registrar Chas. H. Powers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1946 19..... at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19..... to 19.....
and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

Acute Broncho pneumonia
Due to..... 20 hrs

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

S. P. R. & Wells DEPUTY MEDICAL EXAM.
23. SIGNATURE..... WASH. CO., MD.
M. D. or other

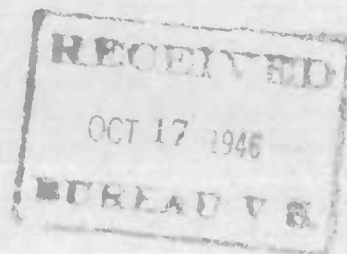
Address Hagerstown, Md. Date signed 10/15/46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Dr. Wells

10365

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Months
 Hospital, institution, or street address where death occurred:
803 Mulberry Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 803 Mulberry Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war no

3. (a) FULL NAME

GUY LINDSAY

3. (b) Social Security Number

217-10-9387

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Katheryn

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1880

8. AGE: Years 66 Months 8 Days 13 If less than one day hrs. min.

9. Birthplace New Windsor Carroll Co., Md.
 (Town, county, and state)

10. Usual occupation Service Mains

11. Industry or business Potomac Edison Co.

12. Name Columbus Lindsay

13. Birthplace Carroll Co. Near Westminster, Md.

14. Maiden name Margaret Ann Bloom

15. Birthplace Carroll Co. Near Westminster, Md.

16. Informant Mrs Isabelle Ross

Address Hagerstown, Maryland

17. Burial Burial Date thereof Oct. 27, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland

19. Oct. 27, 46 Black/Bowen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16, 1946 to Oct. 25, 1946
 and that I last saw him alive on Oct. 27, 1946

Immediate cause of death Coronary Occlusion
(Died in sleep.)

Due to intercoronary

Due to intercoronary

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager
 Address Hagerstown, Md. Date signed 10/25/46

RECEIVED
OCT 29 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 477

CERTIFICATE OF DEATH

10366 302
Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
98 Park Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 98 Park Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

James William Lloyd

3.(b) Social Security Number
219-20-0630

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Hattie Lloyd
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Dec. 27, 1867
8. AGE: Years 78 Months 10 Days 23 if less than one day _____ hrs. _____ min.

9. Birthplace Berryville, Virginia
(Town, county, and state)
10. Usual occupation Park Attendant
11. Industry or business
FATHER 12. Name Deskin Lloyd
13. Birthplace 0----- Va.
MOTHER 14. Maiden name Sarah Fox
15. Birthplace ----- Va.

16. Informant Mrs. R. T. Miller
Address 98 Park Ave.- Hagerstown, Md.
17. Burial Date thereof Oct. 22-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.
18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.
19. Oct 22, 46 East Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1946 9:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Oct 20 1946
and that I last saw him alive on Oct 20 1946

Immediate cause of death Cancer, metastatic DURATION 6 mo.

Due to

Due to

Other conditions Congestive heart failure, right side
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. Layman, M.D. M. D. or other

Address 100 Jefferson City Bldg Date signed 21 Oct 46
Hagerstown, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 69

CERTIFICATE OF DEATH

Dr. Brewer 10367 5

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Days
 Hospital, institution, or street address where death occurred:
674 Penna Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 674 Penna Ave
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

Unnamed Child of Mason F. Long

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

--6. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) October 6 19468. AGE: Years Months Days If less than one day
-- -- 2 -- hrs. -- min.9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

12. Name Mason F. Long13. Birthplace Big Spring Md.14. Maiden name Sarah Socks15. Birthplace Hagerstown Md.16. Informant Mason F. LongAddress Hagerstown Md.17. Burial Date thereof 10/8/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill cemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Oct. 8. 19 46 David H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH October 8 1946 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 6. 19 46 to Oct 8. 19 46
and that I last saw him alive on Oct 7. 19 46

Immediate cause of death

Premature 6 mo. 3 weeks

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David P. Brewer M.D.
Clear Spring Md. M. D. or other
Address Date signed 10/8/46

RECEIVED

OCT 10 1945

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. H.L.Porterfield 37

★ 10368302
Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown RFD #4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Weeks
 Hospital, institution, or street address where death occurred:
Hagerstown RFD #4
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown RFD #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

CHARLES HENRY MARKER

3. (b) Social Security Number

184-09-9419

4. Sex Male 5. Color or race White B.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Pauline Francis Marker
 6.(c) If alive, give age 44 years
 7. Birth date of deceased (mo., day, yr.) November 30, 1900
 8. AGE: Years 45 Months 10 Days 21 It less than one day -- hrs. -- min.

9. Birthplace Sharpsburg Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Foreman

11. Industry or business Poultry Plant

12. Name Franklin Marker

13. Birthplace Sharpsburg Md.

14. Maiden name Hattie Hebb

15. Birthplace Sharpsburg Md.

16. Informant Mrs. Pauline Marker

Address Hagerstown Md.

17. Burial Date thereof 10/24/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Sharpsburg Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct. 24, 46 Black Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 19 46 to Oct 21 19 46

and that I last saw him alive on Oct 20 19 46

Immediate cause of death Rupture aneurysm abdominal aorta
causes
 DURATION 10/21/46
5

Due to causes

Due to causes

Other conditions causes

(Include pregnancy within 3 months of death)

Major findings of operations causes

Date of op. causes

Autopsy results causes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide causes Date of causes

Where did injury occur? causes (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) causes

Means of injury causes Injured at work? causes

23. SIGNATURE H.L. Porterfield M.D.
 M. D. or other causes

Address 136 W Washington Date signed 10/22/46

RECEIVED
OCT 26 1946
BUREAU V *

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

673 Highland Way

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 673 Highland Way

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

J. Victor Martin

3. (b) Social Security Number

212-09-0646

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Nellie L. Martin 61

7. Birth date of deceased (mo., day, yr.) November 13, 1879 6.(c) If alive, give age... years

8. AGE: Years 66 Months 11 Days 20 It less than one day
 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

12. Name Christian W. Martin
 13. Birthplace Roaring Springs, Pa.

14. Maiden name Fanny V. Hoover
 15. Birthplace Leitersburg, Maryland

16. Informant Mrs. J. Victor Martin
 Address Hagerstown, Maryland

17. Burial 10-25-46
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Hagerstown, Maryland
 Location C. M. Suter & Sons

18. Funeral director Hagerstown, Maryland
 Address

19. Oct. 25, 46 Charles H. Bowser
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct, 23 19 46 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January - 19 46 to Oct 23 19 46 and that I last saw him alive on Oct - 23 19 46

Immediate cause of death Hemiplegia - Left - DURATION 6 hrs.

Due to Myocardial heart disease & ?

Due to Probable thrombosis in brain artery - 6 hrs -

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Bowser M. D. or other

Address Hagerstown Md Date signed 10/25/46

RECEIVED
JUL 28 1944
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 years
 Hospital, institution, or street address where death occurred:
101 Blossoms Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 101 Blossoms Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Ella Mabel McDaniel 3. (b) Social Security Number 219-20-2477

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife Leroy McDaniel
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6, 1911
 8. AGE: Years 35 Months 12 Days 12 If less than one day hrs. min.

9. Birthplace Charlestown W. Va.
 (Town, county, and state)

10. Usual occupation Domestic and Laborer

11. Industry or business

FATHER 12. Name David E. Lewis
 13. Birthplace Charlestown, W. Va.

MOTHER 14. Maiden name Anna Russ
 15. Birthplace Charlestown, W. Va.

16. Informant Mrs. Anna Lewis
 Address 101 W. Bethel Street

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 10/22/46
 (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.

18. Funeral director William F. Downey
 Address 2911 Fudich St Hagerstown

19. Oct. 22, 1946 Registrar Beatrice Coward
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 19 46 at 1230 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 46 to Oct 18 19 46
 and that I last saw her alive on Oct 8 19 46

Immediate cause of death Hypertensive Heart Disease
Chronic nephritis
Hypertension
 Due to

DURATION

4 mo" ?" ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip J. Shewman MD

Address 159 W. Washington St M. D. or other

Date signed 10/21/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 24 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

10371

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

20 East Washington Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 East Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Nora Mae Miller

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) March 26, 1883

8. AGE:

Years

Months

Days

If less than one day

6372

_____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Retired Trained Nurse

11. Industry or business

12. Name William A. Miller
13. Birthplace Hagerstown, Wash. Co. Md.14. Maiden name Mary E. Douglas15. Birthplace Hagerstown, Wash. Co. Md.16. Informant Mrs. Florence MotzAddress Hagerstown, Maryland17. Burial Date thereof 10-31-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Oct 29, 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1946 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1945 to 10/28, 1946
and that I last saw him 10/28 alive on 1946

Immediate cause of death

Chronic Endocarditis DURATION 6 yearsDue to (?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations 0Date of op. 0Autopsy results 0PHYSICIAN: Please underline the cause to which death should be charged statistically. No

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Victor D. Miller

23. SIGNATURE

Hagerstown MdM. D. 10/27, 1946Date signed 10/27, 1946

RECEIVED
OCT 31 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10372

★ Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 67 yrs.

Hospital, institution, or street address where death occurred:

38 W. Church St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 38 W. Church St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Bessie Mills

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Charles E. Mills6.(c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) Aug. 8 18798. AGE: Years Months Days If less than one day
67 1 23 hrs. min.9. Birthplace Williamsport, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Henry Robinson13. Birthplace Maryland14. Maiden name Elizabeth McCoy15. Birthplace Maryland16. Informant Charles E. Mills (Husband)Address 38 W. Church St. Williamsport,17. Burial Date thereof Oct. 4 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. Oct 3 19 46 Thos E Lee McCoy
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

Oct/1 1946 1:30P20. DATE OF DEATH Oct/1 1946 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death vascular hypertension, DURATION 1yr.Due to acute pulmonary hemorrhage,due to the vascular hypertension. SUGG.Due to Not due to tuberculosis.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. or

Address Hagerstown, Md. Date signed Oct-2/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1946
BUREAU V.S.

RECEIVED
OCT 7 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 360

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Hillcrest Nursing Home
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Woodpoint
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Blanche P. Minnich

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William H. Minnich
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 2, 1873
 8. AGE: Years 73 Months 7 Days 5 If less than one day..... hrs. min.

9. Birthplace Luray, Virginia
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business
 FATHER 12. Name John Cabbage
 13. Birthplace Luray, Va.
 MOTHER 14. Maiden name Eliza Ann
 15. Birthplace Luray, Va.
 16. Informant Mr. W. H. Minnich
 Address Hagerstown, Md. R D Woodpoint
 17. Burial Date thereof Oct. 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.
 19. Oct. 9, 1946 Blanche P. Minnich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1946 19 11:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1 to 10/7 19 46
 and that I last saw him alive on 10/16 19 46

Immediate cause of death Lytic Cardio-vascular renal disease
 DURATION 20 yrs.

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. H. Minnich M. D. or other
 Address Hagerstown, Md. Date signed 10/18/46

RECEIVED

OCT 11 1945

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

CERTIFICATE OF DEATH

Reg. Diat. No. 342

1. PLACE OF DEATH:

County Washington
City or town Rural Cearfoss, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 2 years
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Rural Cearfoss, Md. Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Broadfording Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

William Clayton Mong

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Lula Hicks Mong
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 30, 1869

8. AGE: Years 77 Months 4 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County Md.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business _____

FATHER 12. Name William H. Mong

13. Birthplace Washington County Md.

MOTHER 14. Maiden name Eliza Sprecher

15. Birthplace Maryland

16. Informant Bernard I. Barnhart

Address Broadfording, Md.

17. Burial Date thereof Oct. 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location near Cearfoss Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct. 30 19 46 Christ H. Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28, 1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21, 1946 to Oct 28, 1946
and that I last saw him alive on Oct 27, 1946

Immediate cause of death _____ DURATION _____

Acute Cardiac Failure Sudden

Due to Chr. Bronchial

Due to Asthma 5 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David P. Brewer M.D. M. D. or other _____

Address Clear Spring Md Date signed 10/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 1 1945
BOSTON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10375

Reg. Dist. No. 862

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 417 W. Wilson Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

BABY BOY MOORE

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 3, 1946
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
7 hrs. min.

9. Birthplace Hagerstown, Washington, Md.
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

FATHER 12. Name Thomas Harper Moore
 13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Mary Elizabeth Richards
 15. Birthplace Hagerstown, Md.

16. Informant Thomas H. Moore
 Address 417 W. Wilson Blvd.

17. Burial Rest Haven Date thereof October 4, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hagerstown Md.
 Location Woodford T. Torment

18. Funeral director Oct. 4, 46
 Address 46 East Howard

19. (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 19 46 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 46 to Oct 4 19 46
 and that I last saw him alive on Oct 4 19 46

Immediate cause of death Prematurity DURATION 7 hours

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other
 Address Hagerstown, Md. Date signed 10-4-46

RECEIVED

OCT 7 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

Reg. Dist. No.

10376 3060

1. PLACE OF DEATH:
 County... Washington
 City or town... Penn Mar 13
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One day
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... No

3. (a) FULL NAME
William Rueben Naylor

3. (b) Social Security Number

181-05-9095

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife... Maude Cline Naylor
 6.(c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) October 15, 1884
 8. AGE: Years 62 Months 13 Days 13 If less than one day hrs. min.

9. Birthplace... Sabillasville, Ford'K. Co. Md
 (Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business

12. Name... William Naylor.
 13. Birthplace Sabillasville, Md.

14. Maiden name... Edith Wagaman.
 15. Birthplace Sabillasville, Md

16. Informant... Harry Naylor.
 Address Highfield, Md

17. Burial Date thereof... Oct. 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Reformed Cemetery
 Location... Sabillasville, Md.

18. Funeral director... M. L. Creager & Son
 Address Thurmont, Md.

19. 10/25/46 19 46
 (Date rec'd by registrar) Registrar Geo. W. Ferguson

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 28, 1946 9:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-10 1939 to 10-28 1946
 and that I last saw him/her alive on 10-28 1946

Immediate cause of death... apoplexy

Due to... Hypertension

Other conditions... Hypertension

Major findings of operations... Hypertension

Antopsy results... Hypertension

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Blue Ridge Summit, Pa 10/30/46

M. D. or other

Date signed... 10/30/46

RECEIVED
NOV 19 1946
BUREAU V &

2-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 68a

CERTIFICATE OF DEATH

Dr. porterfield

10377

20

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
124 East Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 124 East Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS EMMA SUSAN NICODEMUS

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Alfonso
 7. Birth date of deceased (mo., day, yr.) October 4 1876
 8. AGE: Years 70 Months - Days 8 If less than one day
hrs. min.

9. Birthplace Waynesboro Franklin Co. Pa.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home

12. Name Henry Frantz
 13. Birthplace Waynesboro Pa
 14. Maiden name Malinda Miller
 15. Birthplace Waynesboro Pa.

16. Informant Mrs. Ethel Steigman
 Address Hagerstown Md.

17. Burial Date thereof 10/15/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Green Hill Cemetery
Waynesboro Pa.
 Location

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Oct. 14 19 46 Black H. Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 12 1946 19 46, at 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 18 19 45 to Oct 12 19 46
 and that I last saw him alive on Oct 12 19 46

Immediate cause of death
Cerebral hemorrhage
 DURATION
12/18/45
10/10/46

Due to
 Due to
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE H. Porterfield M.D.
 Address 136 W. Wash St. Date signed 10/14/46
 M. D. or other

RECEIVED

OCT 16 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
604 Brighton Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Brighton Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

James Clarence Payne

3. (b) Social Security Number

716-03-2076

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

B.(b) Name of husband or wife Minnie Freeze

7. Birth date of deceased (mo., day, yr.) Nov. 11th 1879 8.(c) If alive, give age 65 years

8. AGE: Years 66 Months 10 Days 29 If less than one day
..... hrs. min.

9. Birthplace Berryville Va
(Town, county, and state)

10. Usual occupation

11. Industry or business Penna R.R.

12. Name James J. Payne

13. Birthplace Loudon Co. Va.

14. Maiden name Mary C. Sheppard

15. Birthplace Clark Co. Va.

16. Informant Lawrence Payne

Address Hagerstown Ind

17. Removal Date thereof Oct 13th 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Mill

Location Berghart Co. W. Va.

18. Funeral director L. F. Beecher

Address Hagerstown - Funkstown

19. Oct 12 1946 Registrar Chas. H. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1946, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25, 1946 to Oct. 10, 1946 and that I last saw him if alive on October 3, 1946

Immediate cause of death Arteriosclerotic heart disease with myocardial degenerating.
Due to
Due to

DURATION About 8 months

Other conditions Chronic cholecystitis

(Include pregnancy within 8 months of death)
Major findings of operations no operation.
Date of op.

Autopsy results no autopsy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ra Bee M. D. or other

Address Hagerstown Ind. Date signed 10-11-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10378

17

RECEIVED

OCT 15 1946

RECEIVED

D. S. Shady

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10379

★ Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
 City or town Yarrowsburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 years
 Hospital, institution, or street address where death occurred:
Knoxville Md. R. 1
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Yarrowsburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Knoxville Md. R. 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Lula Elizabeth Potter

3. (b) Social Security Number

none.

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Emory O. Potter
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 20 - 1873
 8. AGE: Years 72 Months 11 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace New York
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Thomas Jefferson Spencer13. Birthplace New York14. Maiden name Barbara Hoffmaster15. Birthplace Yarrowsburg Wash. Co. Md.16. Informant Mrs. Emory O. PotterAddress Knoxville Md. R. 117. Burial Date thereof October 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church of the Brethren CemeteryLocation Brownsville Md.18. Funeral director Wm. J. Best & SonsAddress Brownsville Md.19. Oct 9 19 46 Cornelius H. Castle
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October - 7 - 19 46 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on Oct 6 19 46 to Oct 6, 1946 19and that I last saw him alive on Oct 6, 1946 19

Immediate cause of death

Terminal Bronchitis - pneumoniaDue to HypertrophicDue to Difficulties

Other conditions _____

DURATION 10 years

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter H. Shady M.D.Address Sharpsburg, Md. Date signed 10/8/46

RECEIVED
OCT 11 1944
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10380
 Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Estella May Smith
 7. Birth date of deceased (mo., day, yr.) May 30 1875 6. (c) If alive, give age _____ years

 8. AGE: Years 71 Months 4 Days 16 If less than one day _____ hrs. _____ min.
9. Birthplace Froyville Md
(Town, county and state)10. Usual occupation Retired Railroad Worker11. Industry or business Western Maryland R.R.12. Name Upton Pryor13. Birthplace Fredrick Co Md14. Maiden name Let Barsnyder15. Birthplace Fredrick Co Md16. Informant Mrs. Bawn McBreiaAddress Highfield Md17. Burial Date thereof 10 19 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Smithsburg CemeteryLocation Smithsburg Md18. Funeral director Walter H GroveAddress Waynesboro, Penna19. Oct 9 19 46 Geo. W. Tamm
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 19 46 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-10- 19 46 to 10-17- 19 46and that I last saw him alive on 10-17- 19 46Immediate cause of death Chronic MyocarditisOther conditions Chronic Bronchial Asthma

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

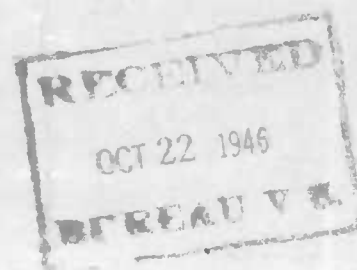
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Geo. W. Tamm Blue Ridge Summit Pa
Date signed 10/19/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

10381
Reg. Diat. No. 3020

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
N. Jonathan Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. N. Jonathan Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Violet S. Richardson

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife William Richardson
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) January 6, 1905

8. AGE: 40 Years 10 Months 26 Days If less than one day
 hrs. min.

9. Birthplace Mt. Pleasant, Pa.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Samuel Coy

13. Birthplace Mt. Pleasant, Pa.

14. Maiden name Daisy Shammell

15. Birthplace Mt. Pleasant, Pa.

16. Informant Mrs. Daisy Coy

Address Mt. Pleasant, Pa.

17. Burial Date thereof 11/4/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director William H. Danner

Address 291 Predunich St. Hagerstown

19. November 4, 46 Registrar Blair Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1946, at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 1946 to Oct 31 1946 and that I last saw him alive on Oct 31 1946

Immediate cause of death Cerebral hemorrhage DURATION 1 hour

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. J. Rather M. D. or other

Address Hagerstown, Md. Date signed Nov. 1, 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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96

Reg. Dist. No. 302

Reg. Diat. No.202.....

2.(a) If veteran, name war.....

None

19. Oct. 8. 46 Chas H Bowers
(Date rec'd by registrar) Registrar

Address 154 W. Wash. St. Date signed Feb 20 1941

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten signature

RECEIVED
OCT 10 1946
BUREAU VS

9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

10383

Reg. Dist. No. 305

1. PLACE OF DEATH:

County... Washington

City or town... Breathedsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 1/8/46

Hospital, institution, or street address where death occurred:

Md. State Reformatory for Males

How long in hospital or institution? since 4/8/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard

City or town... Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war... unknown

3. (a) FULL NAME

ARTHUR RULEY

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

NEGRO

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife... single

6.(c) If alive, give age... 43 years

7. Birth date of deceased (mo., day, yr.) 12/2/02

8. AGE: Years Months Days If less than one day

43

10

--

hrs. min.

9. Birthplace... Cecil County, Md.

(Town, county, and state)

10. Usual occupation... laborer

11. Industry or business... ---

12. Name... William Ruley

13. Birthplace... unknown

14. Maiden name... No Record

15. Birthplace... No Record

16. Informant... Md. State Reformatory for Males

Address... Breathedsville, Md.

17. Burial Date thereof... 10/7/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Penal Farm Cemetery

Breathedsville, Md.

Location... Md. State Ref. for Males

18. Funeral director... Andrew K. Coffman

Address... Hagerstown Md.

19. Oct 7 1946 John H. Bass

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 2 1946 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 21 1946 to Oct 2 1946

and that I last saw him alive on Oct 2 1946

Immediate cause of death... PULMONARY TUBERCULOSIS

DURATION

5 yrs.

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Autopsy results... Not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert P. Conrad, M.D.

M. D. or other

Address... Hagerstown, Md.

Date signed... 10-3-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LIVED
OCT 11 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3000

1. PLACE OF DEATH:

County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

William Elmer Sampson

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife _____

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 16, 1872

8. AGE: Years 74 Months 3 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Greencastle-Franklin-Penna
(Town, county, and state)10. Usual occupation Retired Molder

11. Industry or business _____

12. Name Joseph Sampson13. Birthplace Scranton, Penna14. Maiden name Sarah Stoner15. Birthplace Greencastle, Penna16. Informant Harry SampsonAddress Sharpsburg, Maryland

17. Burial Date thereof Oct. 12, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar GroveLocation Chambersburg, Penna18. Funeral director R. I. EarnshawAddress Keedysville, Md

19. 10/11 19 46 Chas Bogue
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 19 46 at 3:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19 47 to Sept 9 19 46and that I last saw him alive on Sept 5 19 46Immediate cause of death wreck

DURATION

Due to Chronic pyelo-nephritis 2 yearsDue to Cystitis 5 yearsDue to Chronic prostatitis 5 yearsOther conditions Chronic myocarditis 2 years

(Include pregnancy within months of death)

Major findings of operation Hypothymy & infection of prostate 4 yrs ago

Autopsy results _____ Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter H. Shively M.D.Address Sharpsburg, Md M. D. or other _____Date signed 10/11/46

2-50



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Dr. Ralph Young

10385

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Route #2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 52 Years
 Hospital, institution, or street address where death occurred:
Hopewell Road
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R# 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hopewell Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. FLORENCE VIRGINIA SCHINDEL

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Frank Schindel

7. Birth date of deceased (mo., day, yr.) May 3, 1865 6. (c) If alive, give age --- years

8. AGE: Years 81 Months 5 Days 12 It less than one day --- hrs. --- min.

9. Birthplace Big Springs Washington Co. Md.
 (Town, county, and state)

10. Usual occupation House wife11. Industry or business Own Home12. Name Denton Weaver13. Birthplace Romney W. Va.14. Maiden name Anna Baylor15. Birthplace Big Springs Md.16. Informant Jesse H. FeidtAddress Hagerstown Md. R# 2

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 10/18/46
 (month) (day) (year)

Cemetery or crematory Manor CemeteryLocation Near Tilghmanton Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 18 46 Registrar Charles Bowers

(Date rec'd by registrar) 19 46 Registrar Charles Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 19 46 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15/46 to 10/15/46 and that I last saw him alive on 10/15/46

Immediate cause of death Bronchial Occlusion DURATION 1 Day

Due to -----Due to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE R. P. Young M. D. or other -----Address ----- Date signed 10/17/46

RECEIVED

OCT 22 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 103863 303

1. PLACE OF DEATH:

County WashingtonCity or town Clear Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Clear Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Downs Schnebly4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Harry Schnebly7. Birth date of deceased (mo., day, yr.) Sept. 26, 1864 6.(c) If alive, give age 86 years8. AGE: Years 82 Months 1 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Dale County, Illinois
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business

12. Name Lewis Downs13. Birthplace Downsville, Maryland14. Maiden name Maria Downey15. Birthplace Downsville, Maryland16. Informant Mrs. Maria AngleAddress Big Spring, Maryland17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Oct. 29, 1946
(month) (day) (year)Cemetery or place of interment St. Paul'sLocation Near Clear Spring, Maryland18. Funeral director Snyder - RowlandAddress Clear Spring, Maryland19. 10/28 46 Joseph W. Murray
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 19 46, at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26, 19 46, to Oct 26, 19 46and that I last saw him/her alive on Oct 26, 19 46

Immediate cause of death _____

Acute Cardiac Failure SuddenDue to Acute Gastritis 8 hrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE David P. Brewer M.D. M. D. or other _____Address Clear Spring Md. Date signed 10/28/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 30 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

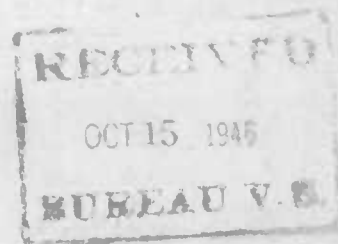
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10387

Reg. Dist. No. 302

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Now long in above place of death?..... <u>29 years</u> Hospital, institution, or street address where death occurred: <u>1100 Virginia Ave.</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) <u>1100 Virginia Ave.</u> Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>John W. Seibert</u>				3. (b) Social Security Number <u>220-10-3617</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Nellie Seibert</u>				6. (c) If alive, give age <u>72</u> years			
7. Birth date of deceased (mo., day, yr.) <u>November 28, 1869</u>				8. AGE: Years <u>76</u> Months <u>11</u> Days <u>13</u> If less than one day..... hrs. min.			
9. Birthplace <u>Martinsburg Berkley W. Va.</u> (Town, county, and state)				10. Usual occupation <u>Retired</u>			
11. Industry or business <u>Mill Worker</u>				12. Name <u>Barney C. Seibert</u>			
13. Birthplace <u>Martinsburg W. Va.</u>				14. Maiden name <u>Sarah J. Pitzer</u>			
15. Birthplace <u>Martinsburg W. VA.</u>				16. Informant <u>Mrs. Nellie Seibert</u> Address <u>Hagerstown Md.</u>			
17. Burial (Burial, cremation, or removal. Which?)..... <u>10-13-46</u> (month) (day) (year) Cemetery or crematory..... <u>Rose Hill Cemetery</u> <u>Hagerstown Md.</u> Location.....				18. Funeral director <u>Scott F. Minnich & Son</u> Address <u>Hagerstown Md.</u>			
19. (Date rec'd by registrar) <u>Oct. 13, 46</u>				20. DATE OF DEATH <u>October 11, 1946</u> at <u>6</u> a. m.			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1944</u> to <u>10-11</u> 19 <u>46</u> and that I last saw him alive on <u>10-8-46</u> 19.....							
Immediate cause of death <u>Cardiac Decompensation -</u> <u>Myocardial Heart disease -</u> Due to..... Due to..... Other conditions..... <u>Several Edema -</u> (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
23. SIGNATURE <u>Theresa C. Bowers</u> Address..... <u>Hagerstown Md.</u> Date signed <u>10/12/46</u> Registrar							



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10388 302

1. PLACE OF DEATH Washington
 County Hagerstown
 City or town 52 years
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Hospital
15 weeks
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 27 N. Locust St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

Grace I. Seiss

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) September 21, 1873

8. AGE: Years 73 Months 1 Days 7 If less than one day
 hrs. min.

9. Birthplace Sharpsburg Wash. Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Hiram S. Seiss
 13. Birthplace Sharpsburg Md.

14. Maiden name Mary Cramer
 15. Birthplace Sharpsburg Md.

16. Informant Mrs. Mary Yeakle
 Address Herndon Va.

17. Burial 10-30-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Sharpsburg Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Oct. 30, 46 Registrar Chas. H. Bowman
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 46 at 10:25a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12, 45 to Oct. 28, 46
 and that I last saw or alive on Oct. 27, 46

Immediate cause of death Circumferential Pylorus of Stomach DURATION Nov. 1945

Due to arteriosclerosis 1 yr +

Due to chronic myocarditis 1 yr +

Other conditions secondary anemia 6 months

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Yeakle M. D. or other
 Address Hagerstown Md. Date signed 10-28-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 1 1945
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10389

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 years
 Hospital, institution, or street address where death occurred:
22 E. Lee Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 22 E. Lee Street
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Della May Shank

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) May 12, 1906

8. AGE: Years 40 Months 4 Days 27 If less than one day
 hrs. min.

9. Birthplace Washington County, Md.
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name Jacob B. Monninger

13. Birthplace ----- Penn.

MOTHER 14. Maiden name Bella M. Drury

15. Birthplace ----- Md.

16. Informant Jacob B. Monninger

Address Hagerstown, Md. R D

17. Burial Date thereof Oct. 12-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct 12, 46 Registrar Chas H Powers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1946 19 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to Oct 9 19 46
 and that I last saw h. e. r. alive on Oct 8 19 46

Immediate cause of death Carcinomatous DURATION
generalized; primary
site, uterus

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Campbell M.D. M. D. or other

Address 145 W. Washington St Date signed Oct 13, 46

RECEIVED
OCT 15 1946
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
Spelling of birth place is
43- on 108 film no. 12/ 16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10390

Reg. Dist. No. 306

1. PLACE OF DEATH

County Washington
City or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yr.
Hospital, institution, or street address where death occurred: -

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington
City or town Smithsburg md
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Robert E. Smith

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Laura Smith
7. Birth date of 5-18-62 6.(c) If alive, give age 26 years
deceased (mo., day, yr.)

8. AGE: Years 84 Months 5 Days 19 If less than one day - hrs. - min.

9. Birthplace Parranta Pa (Town, county, and state)

10. Usual occupation W.M. PR Agent - Retired

11. Industry or business -

12. Name Robert E. Smith

13. Birthplace Parranta Pa

14. Maiden name Elmunda Simpson

15. Birthplace Baltimore md

16. Informant Laura Smith

Address Smithsburg md

17. Burial Smithsburg md Date thereof 10-27-1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Smithsburg md

Location Smithsburg md

18. Funeral director Geo. B. Hoover

Address Smithsburg md

19. Oct 25-46 19 46 Registrar Geo. W. Ferguson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1946 at 2:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Oct 23 1946

and that I last saw him alive on Oct 23 1946

Immediate cause of death Pulmonary Edema DURATION 6 hrs

acute

Due to acute coronary artery disease 10 yrs

Due to arteriosclerosis 16 yrs

Sclerosis 2 yrs

Other conditions chronic prostatitis

Hypertension (Include pregnancy within 8 months of death)

Major findings of operations -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. E. K. O'Brien M. D. or other

Address Smithsburg md Date signed 10/25/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13a

CERTIFICATE OF DEATH

Reg. Dist. No. 10391 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
8 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Hagerstown Route #6
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Rural Hagerstown Route #6
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Maugansville, Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Minnie M. Stine

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Charles C. Stine
 6.(c) If alive, give age..... 59 years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 9, 1881
 8. AGE: Years..... 64 Months..... 9 Days..... 28 If less than one day..... hrs. min.

9. Birthplace..... Franklin County, Pa.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business.....

FATHER 12. Name..... John C. Black
 13. Birthplace..... Adams County, Pa.
 MOTHER 14. Maiden name..... Anna R. Talhem
 15. Birthplace..... Franklin County, Pa.

16. Informant..... Charles C. Stine
 Address..... Hagerstown Route, #6

17. Burial..... Date thereof..... 10-9-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Union Cemetery

Location..... Shady Grove, Pa.
 18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Oct 8. 19 46 Chas H Bowen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 10-7-46 19..... at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10-1-46 19..... to 10-7-46 19.....
 and that I last saw her alive on 10-6-46 19.....

Immediate cause of death.....
Coronary Arteriosclerosis
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... W. S. Suter M. D. or other
 Address..... Hagerstown, Md Date signed..... 10/9/46

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OCT 10 1946

BUREAU VS

P. J. H.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 weeks
 Hospital, institution, or street address where death occurred:
Washington county Hospital
 How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Downsville Pike
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. NELLIE ALICE STOCKSLAGER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Albert L.
 6. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) March 1 1886
 8. AGE: Years 60 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Funkstown Wash. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name William Welty13. Birthplace Funkstown Md.14. Maiden name Jennie Monegan15. Birthplace St. James Md.16. Informant Albert L. StockslagerAddress Hagerstown Md. R # 217. Burial Date thereof 10/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md19. Oct 14 19 46 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1946 19 46 at 4 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 46 to Oct 13 19 46
 and that I last saw him alive on Oct 12 19 46

Immediate cause of death Carcinoma Stomach
 DURATION 3

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Porterfield M.D. M. D. or other _____Address 136 W Washington Date signed 10/14/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 16 1946
BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Dr. Binkley 10393

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 502 Summit Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

CLAYTON HAYS SUMMERS

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife Jeannette Summers

7. Birth date of deceased (mo., day, yr.) February 12, 1860 6. (c) If alive, give age. --- years

8. AGE: Years 86 Months 8 Days 9 If less than one day --- hrs. --- min.

9. Birthplace Myersville Fredrick Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business Retired12. Name Lawson H. Summers13. Birthplace Myersville Md.14. Maiden name Mary Russard15. Birthplace Myersville Md.

16. Informant Mrs. Ora M. Falls
 Address Hagerstown Md.

17. Burial Burial Date thereof 10/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Luthern CemeteryLocation Middletown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 21, 1946 Chas H. Rowles
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 19, 1946 at 4A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 18, 1946 to Oct 19, 1946 and that I last saw him alive on Oct 19, 1946

Immediate cause of death Pneumonia (Rt. Base) DURATION 2 days

Color pneumonia. Surg.
 Due to Upper Respiratory Infection 1 week

Other conditions Chr. myocarditis 10 yrs
arterio sclerosis 10 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE O. H. Binkley, M.D. M. D. or other
 Address Hagerstown Md. Date signed 10/19/46

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OCT 23 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

 10394
 Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
61 E. Baltimore St.
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 61 E. Baltimore St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3. (a) FULL NAME

Caroline Swayne

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Samuel
 6. (c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) October 31, 1863
 8. AGE: Years 82 Months 11 Days 6 If less than one day --- hrs. --- min.

9. Birthplace Ambsrosia Iowa
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Hamilton Eichelberger
 13. Birthplace Illnoise
 14. Maiden name Ann Boulette
 15. Birthplace Sharpsburg Md.

16. Informant Miss Ora Gordon
 Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) 10/9/46
 (month) (day) (year)
 Cemetery or crematory Elmwood Cemetery
 Location Shepardstown W. Va.

18. Funeral director Andrew K. Coffran
 Address Hagerstown Md.

19. Oct. 8. 46 B. Easthrowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 19 46 at 4:30 p. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 45 to Oct 7 19 46
 and that I last saw him/her alive on Oct 7, 1946 19 ---

Immediate cause of death Ch. Myocarditis
 DURATION 8 yrs.

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE Robert P. Conrad M. D. or other

Address Hagerstown, Md Date signed 10-7-46

RECEIVED

OCT 10 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

10395

Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....Washington
 City or town.....Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs.
 Hospital, institution, or street address where death occurred:
1216 Virginia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Washington
 City or town.....Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....1216 Virginia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

EMMA ELIZABETH TEETER

3. (b) Social Security Number

none

4. Sex.....F 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Joseph G. Teeter
 6.(c) If alive, give age.....79 years
 7. Birth date of deceased (mo., day, yr.).....April 4, 1864
 8. AGE: Years.....82 Months.....6 Days.....10 If less than one day..... hrs. min.

9. Birthplace.....Mercersburg, Penna.
 (Town, county, and state)
 10. Usual occupation.....Housewife
 11. Industry or business.....
 12. Name.....Thomas Taylor
 13. Birthplace.....Penna.
 14. Maiden name.....Susan Sword
 15. Birthplace.....Penna.

16. Informant.....Joseph G. Teeter
 Address.....1216 Virginia Ave., Hagerstown, Md.
 17. Burial..... Date thereof.....Oct. 17, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....Fairview Cemetery
 Location.....Mercersburg, Penna.
 18. Funeral director.....Jacob Teeter
 Address.....Greencastle, Penna.
 19. Oct. 15, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct 14 1946, at 1:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Oct 14 1946
 and that I last saw him alive on Oct 17 1946
 Immediate cause of death.....Chv Myocarditis
 DURATION.....6 yrs
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....Robert P. Conrad, M.D.
 Address.....Hagerstown, Md M. D. or other.....
 Date signed.....10-15-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 17 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10395 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mo
 Hospital, institution, or street address where death occurred:
Hillcrest Convalescent Hospital
 How long in hospital or institution? 6 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Franklin
 City or town Waynesboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 133 East Second
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Mrs. Hattie Wallace

3. (b) Social Security Number

4. Sex F 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Johnson Wallace
 6.(c) If alive, give age 83 years
 7. Birth date of deceased (mo., day, yr.) May 5, 1864

8. AGE: Years 82 Months 5 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John M. Canty
 13. Birthplace Hagerstown, Md.

14. Maiden name Mary C. Hoffman
 15. Birthplace Chambersburg, Pa

16. Informant Mr. Johnson Wallace
 Address Hillcrest Hagerstown, Md.

17. Burial Date thereof 10/17/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Burn Hill
 Location Waynesboro, Pa

18. Funeral director Halton & Sons
 Address 274 Church St. Waynesboro, Pa

19. Oct. 15 19 46 Chas. H. Rogers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 19 46 at 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46 to 10-15 19 46
 and that I last saw him alive on 10-15 19 46

Immediate cause of death Chronic Myocarditis DURATION 2 yrs
 Due to Bronchial 2 yrs
Asthma
 Due to Asteria - tubercularis 2 yrs
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert B. Bugown M.D. M. D. or other
 Address Waynesboro, Pa. Date signed 10-15-46

RECEIVED
OCT 18 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

10397

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Wilson Blvd.
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

JAMES EDWARD WELLER

3. (b) Social Security Number

215-05-2284

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

6. (b) Name of husband or wife

Bessie Weller6. (c) If alive, give age 62 years

7. Birth date of

deceased (mo., day, yr.)

October 4, 1883

8. AGE:

Years

Months

Days

If less than one day

63025-- hrs.-- min.9. Birthplace Clear Spring Washington Co., Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Victor Products Co.

FATHER

12. Name

Jonathan Weller

13. Birthplace

Clear Spring Md.

MOTHER

14. Maiden name

Mary Shank

15. Birthplace

Clear Spring Md.

16. Informant

Milton E Weller

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

10/31/46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19.

46Blair Bowers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Acute coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Robert West
DEPUTY MEDICAL EXAM.
WASH. CO., MD.
M. D. orAddress Hagerstown, Md.Date signed 10/30/46

RECEIVED

NOV 2 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Norment

10398

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 112 North Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3. (a) FULL NAME

LEONARD LEE WHITTINGTON

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife ---

7. Birth date of deceased (mo., day, yr.) October 8, 1946 6. (c) If alive, give age --- years

8. AGE: Years -- Months -- Days -- If less than one day 12 hrs. min.

9. Birthplace Hagerstown Washington Co., Md.
 (Town, county, and state)

10. Usual occupation None11. Industry or business ---12. Name Charles E. Whittington13. Birthplace Hagerstown Md.14. Maiden name Betty Jene Dixon15. Birthplace Hagerstown Md.16. Informant Charles E. WhittingtonAddress Hagerstown Md.

17. Burial Date thereof October 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Oct. 9. 46 Blaseth Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1946, at 8:30 AM

21. I CERTIFY that Death occurred on the date above stated; that I attended deceased from

October 8 1946 to October 9 1946
 and that I last saw him alive on October 8 1946

Immediate cause of death Asphyxia neonatorum

DURATION

Due to (Wrapping of umbilical cord)Due to around neck -Other conditions ---

(Include pregnancy within 8 months of death)

Major findings of operations 0Date of op. ---Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

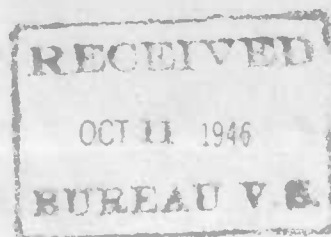
Accident, suicide, or homicide 0 Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Norment M. D. or otherAddress Hagerstown Md. Date signed 10/9/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred:

Byrons Tannery

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Frederick St.
(If rural, give LOCATION)2.(a) If veteran, name war World War #1

3. (a) FULL NAME

Edgar E Wiley

3. (b) Social Security Number

215-01-9961

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ruth Miller Wiley5. (c) If alive, give age 46 yrs.7. Birth date of deceased (mo., day, yr.) April 10 18998. AGE: Years Months Days If less than one day
47 5 21 hrs. min.9. Birthplace Williamsport, Md.
(Town, county, and state)10. Usual occupation Tacker at Tannery11. Industry or business Byrons Tannery12. Name George Wiley13. Birthplace Big Poole Md.14. Maiden name Valletta Turner15. Birthplace Williamsport, Md.16. Informant Mrs. Ruth Miller Wiley (wife)Address Williamsport, Maryland17. Burial Date thereof Oct. 4 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Maryland18. Funeral director Edith W. LeafAddress #7 Church St. Williamsport, Md.19. Oct. 3 1946 Mrs E Lee M. Elroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct/1 1946, at 2 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw h. alive on 19

Immediate cause of death

suffocation bystrangulation

Due to

Fracture Hyoid bone

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accide nt Date Oct/1/46Where did injury occur? Williamsport Wash. Md.
(City or town) (County) (State)Injured at home, farm, todustry, public place (where?) Byron's TanneryMeans of injury Steel plates fell across neck yes

DEPUTY MEDICAL EXAM.

23. SIGNATURE S. R. Wells WASH. CO., MD.Address Hagerstown, Md. Date Oct 2/46

RECEIVED

OCT 7 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1240)

CERTIFICATE OF DEATH

Reg. Dist. No. 10400 306

1. PLACE OF DEATH:

County WashingtonCity or town Highfield
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WashingtonCity or town Highfield
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war World War I

3. (a) FULL NAME

Allen Oscar Willard

3. (b) Social Security Number

217-18-7411

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 21st. 1894 6. (c) If alive, give age _____ years

8. AGE:

Years 52Months 8Days 6

If less than one day

_____ hrs. _____ min.

9. Birthplace Foxville Fredk. Co. MD
(Town, county, and state)
Laborer

10. Usual occupation

11. Industry or business

12. Name Joseph Willard13. Birthplace Foxville. Fredk Co MD
Clara Mc Afee

14. Maiden name

15. Birthplace Foxville. Fredk Co MD16. Informant Joseph Willard
Highfield. MD

Address

17. Burial Date thereof Oct. 30th. 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Mt. Mariah Cem
Foxville. Fredk Co. MD

Location

18. Funeral director M. L. Creager & Son.
Thurmont. MD

Address

19. Oct 29 1946 Geo. V. Ferguson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1946 at 11 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Oct 27 1946
and that I last saw him alive on 10-27-1946

Immediate cause of death

DURATION

Alcohol
Chronic Alcoholic
of the Liver
Serosis
Due to _____
Due to _____
Other condition _____

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Blue Bridges M. D. or other
Blue Bridges Date signed 10/27/46

RECEIVED
NOV 1 1946

Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

FILM No. I 07 OCT 18 1946

1. PLACE OF DEATH:

County Washington County
City or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 yrs
Hospital, institution, or street address where death occurred:
Williamsport, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Artizan St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sam Joseph Williams

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lenora Williams
6.(c) If alive, give age 68 yrs

7. Birth date of deceased (mo., day, yr.) Feb. 13 1865
8. AGE: Years 80 Months 8 Days 3 It less than one day _____ hrs. _____ min.

9. Birthplace Williamsport, Maryland
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business Farm

12. Name Calvin Williams

13. Birthplace Williamsport, Md.

14. Maiden name Elenora Keller

15. Birthplace Va

16. Informant Lenora Williams (wife)
Address Williamsport, Md.

17. Burial Date thereof Oct. 15 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Maryland

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md.

19. Oct. 15 19 46 Mrs E Lee McChoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1946 at 6:47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 19 46 to Oct 12 19 46
and that I last saw him alive on Oct 12 19 46

Immediate cause of death Coronary Occlusion

Due to _____
Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE E. P. Young

Address Williamsport, Md.

Date signed Oct 16

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 17 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10402

307

1. PLACE OF DEATH:

County WashingtonCity or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yearsHospital, institution, or street address where death occurred: Rohersville Md.How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rohersville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, name war none

3. (a) FULL NAME

Morris Hezekiah Zecher

3. (b) Social Security Number

703-07-93604. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Ora Bealer Zecher7. Birth date of deceased (mo., day, yr.) October 27 - 1882 6. (c) If alive, give age years8. AGE: Years 63 Months 11 Days 29 If less than one day hrs. min.9. Birthplace Burkittsville Fred. Co. Md.
(Town, county, and state)10. Usual occupation Employee of Co. Road Dept.

11. Industry or business

12. Name Carlton Zecher13. Birthplace Burkittsville Fred. Co. Md.14. Maiden name Margaret Dean15. Birthplace Middleton Fred. Co. Md.16. Informant Mrs. Ora ZecherAddress Rohersville Md.17. Burial - Date thereof Oct. 29, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rohersville CemeteryLocation Rohersville Md.18. Funeral director Wm. J. Burt & SonsAddress Boonsboro Md.19. Oct. 28 19 46 Mrs. Katherine Dagenhart

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct/26/46 19 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 and that I last saw him alive on 19 Immediate cause of death acute coronary thrombosisDue to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results as above Oct/27/46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Parker & Wells DEPUTY MEDICAL EXAMINERAddress Hagerstown, Md. WASH. CO. MD.Date signed Oct. 27, 46

RECEIVED
OCT 30 1946
BUREAU OF